Group Benefits

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Simsbury, Connecticut
(A stock insurance company)

Policyholder: **WAL-MART STORES, INC.**

Policy Number: GLT-205215
Policy Effective Date: January 1, 1990

Policy Number: GLT-024554
Policy Effective Date: September 1, 1988

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and The Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for the Company

Richard G. Costello, ***Secretary***

Thomas M. Marra, ***President***

READ YOUR CERTIFICATE CAREFULLY

You have a 30 day right from Your original Certificate Effective Date to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days of Your original Certificate Effective Date. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.

A note on capitalization in this certificate:

Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

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Form GBD-1200

SCHEDULE OF INSURANCE

The Policy of long term Disability insurance provides You with long term income protection if You become Disabled from a covered injury, sickness or pregnancy. Please refer to Your group enrollment form to see the Option that applies to You.

THE BENEFITS DESCRIBED HEREIN ARE THOSE IN EFFECT AS OF JANUARY 1, 2006.

Cost of coverage: You must contribute toward the cost of coverage.

Eligible Class(es) for Coverage: All Full-time Active Associates who are citizens or legal residents of the United States, its territories and protectorates; excluding temporary, leased or seasonal Associates, as follows:

Class 1: All Full-time Non-Puerto Rico Hourly Associates, except in Class 2 or 3.
Class 2: All Full-time Hourly Field Logistics Associates, Hourly Field Supervisor positions in stores and clubs, and Hourly Pharmacists not do not work in California, excluding Associates who work in Puerto Rico.
Class 3: All Full-time Hourly Pharmacists who work in California.
Class 4: All Full-time Salaried Associates, Management, Pharmacists, and Pilots who do not work in Puerto Rico.

Full-time **Employment:** the minimum number of hours per week indicated for You in Wal-Mart's payroll system.

With respect to All Full-time Active Associates who enroll on time:
Maximum Monthly Benefit: $10,000
Benefit Period Percentage: 50%

With respect to All Full-time Active Associates who are late enrollees with Disability dates commencing less than or equal to 5 years after coverage effective date:
Maximum Monthly Benefit: $10,000
Benefit Period Percentage: 40%

With respect to All Full-time Active Associates who are late enrollees with Disability dates commencing greater than 5 years after coverage effective date:
Maximum Monthly Benefit: $10,000
Benefit Period Percentage: 50%

With respect to All Full-time Active Associates:
Minimum Monthly Benefit: $50.00

Eligibility Waiting Period for Coverage: The number of days of continuous service, as shown below for Your class:

Class 1: 180 days from Your date of hire.
Class 2: 90 days from Your date of hire.
Class 3: 90 days from Your date of hire.
Class 4: The date You enter the eligible class.

The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a Full-time or Part-time Active Associate with the Employer in an eligible class under the Prior Policy.

Elimination Period:

With respect to Classes 1, 2 and 3, it is the later of:
1) the first 180 consecutive day(s) of any one period of Total Disability; or
2) the end of Your Employer-sponsored Weekly Disability benefits.

With respect to Class 4, it is the later of:
1) the first 90 consecutive day(s) of any one period of Total Disability; or
2) the end of Your Employer-sponsored salary continuation program.

MAXIMUM DURATION OF BENEFITS TABLE

Age When Disabled	Benefits Payable
Prior to Age 62	To Age 65
Age 62	48 months
Age 63	42 months
Age 64	36 months
Age 65	30 months
Age 66	27 months
Age 67	24 months
Age 68	21 months
Age 69 and over	18 months

DEFINITIONS

Actively at Work means at work with the Employer on a day that is one of Your scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your Occupation in the usual way and for Your usual number of hours. We will consider You Actively at Work on a day that is not a scheduled work day only if You were Actively at Work on the preceding scheduled work day.

Active Associate means an Associate who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance. With respect to the regular duties of a **Salaried Employee**, Active Associate means an Associate who only performs tasks which are administrative, sales or supervisory, and is paid by the Employer on a regular, salaried basis. With respect to the regular duties of a **Non-Salaried Employee**, Active Associate means an Associate who is paid by the hour and who does not meet This Policy's definition of "Salaried Associate."

Any Occupation means any occupation for which You are qualified by education, training or experience that has an earnings potential greater than the lesser of:

1) 50% of Your Pre-disability Earnings; or
2) the Maximum Monthly Benefit.

Current Monthly Earnings means monthly earnings You receive from:

1) the Employer; and
2) other employment;

while You are Disabled and eligible for the Disabled and Working Benefit.

Disabled and Working (*Partially Disabled*) means for the first 12 months immediately following the Elimination Period, that You are prevented by:

1) accidental bodily injury;
2) sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy;

from performing the Essential Duties of Your Occupation, are working on a part-time or limited duty basis, and as a result, Your Current Monthly Earnings are more than 20%, but are less than or equal to 80% of Your Pre-disability Earnings.

After 12 months following the Elimination Period, You are prevented by:

1) accidental bodily injury;
2) sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy;

from performing the Essential Duties of Any Occupation, are working on a part-time or limited duty basis, and as a result, Your Current Monthly Earnings are more than 20%, but are less than or equal to 50% of Your Indexed Pre-disability Earnings.

Disability or Disabled means Total Disability or Disabled and Working (Partially Disabled).

Elimination Period means the period of time You must be Totally Disabled before benefits are payable. The Elimination Period is shown in the Schedule of Insurance.

Employer means the Policyholder.

Essential Duty means a duty that:

1) is substantial, not incidental;
2) is fundamental or inherent to the job; and
3) cannot be reasonably omitted or changed.

Your ability to work the number of hours in Your regularly scheduled workweek is an Essential Duty.

Mental Illness means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of The Policy, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:

Mental Retardation;

1) Pervasive Developmental Disorders;
2) Motor Skills Disorder;
3) Substance-Related Disorders;
4) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
5) Narcolepsy and Sleep Disorders related to a General Medical Condition.

Monthly Benefit means a monthly sum payable to You while You are Disabled, subject to the terms of The Policy.

Other Income Benefits means the amount of any benefit for loss of income provided to You as a result of the period of Disability for which You are claiming benefits under The Policy. This includes the amount of disability or annuity benefits pursuant to any:

1) group insurance or pension plan;
2) Railroad Retirement Act;
3) plan or arrangement of coverage, whether insured or not, which is received from the Employer as a result of employment by or association with the Employer, or which is the result of membership in or association with any group, association, union or other organization or plan provided by law;
4) pension benefits that commence after the date of Disability and any disability-based pension benefits;
5) temporary, permanent disability, or impairment benefits for which You are entitled under a Workers' Compensation Law, occupational disease law, unemployment compensation law, similar law or substitutes or exchanges for such benefits;
6) any damages or settlement (exclusive of fees and interest) which is made in lieu of Workers' Compensation benefits and paid to You, Your Employer, or a Workers' Compensation insurer, but only to the extent that any damages or settlement represent Your loss of income;
7) the amount of disability or retirement benefits under the United States Social Security Act, to which You and Your spouse and/or children may be entitled because of Your Disability or retirement; or
8) portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for Your loss of earnings.

Other Income Benefits will also include:

1) early retirement benefits, if You so elect;
2) disability income benefits under a group life insurance plan, regardless of whether You elect to apply for such benefits;
3) temporary, permanent disability, or impairment benefits provided under a Workers' Compensation Law or any other similar law or exchanges for such benefits; or
4) any "no-fault" automobile insurance plan.

If You are paid Other Income Benefits in a lump sum or settlement, You must provide proof satisfactory to Us of:

1) the amount attributed to loss of income; and
2) the period of time covered by the lump sum or settlement.

We will pro-rate the lump sum or settlement over this period of time. If You cannot or do not provide this information, We will assume the entire sum to be for loss of income, and the time period to be 24 months. We may make a retroactive allocation of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of Your claim.

The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:

1) takes effect after the date benefits become payable under The Policy; and
2) is a general increase which applies to all persons who are entitled to such benefits.

Other Income Benefits will *not* include:

1) proceeds from any:
   a) source of personal investment income;
   b) individual disability income policy, unless the policy is obtained through a group-sponsored or employer-related program; or
   c) Veteran's Administration Disability benefits;
2) benefits from military retirement pension plans;
3) distribution from any form of profit sharing, regardless of pre-tax or post-tax treatment, as indicated under Section 401(k) of the Internal Revenue Code; or
4) proceeds or income from any:
   a) individual or employer-sponsored I.R.A., Individual Tax Sheltered Annuity, or any deferred compensation plan;
   b) Employee Stock Option Plan or any thrift plan;
   c) a partner or proprietor H.R. 10 (Keough Plan) under the Self-Employed Individual Tax Retirement Act; or
   d) a capital account.
5) the amount of any increase in benefits paid under any federal or state law, if the increase:
   a) takes effect after the date benefits become payable under The Policy; and
   b) is a general increase which is required by law and applies to all persons who are entitled to such benefits.

Physician means a legally qualified physician or surgeon other than a physician or surgeon who is Related to You by blood or marriage.

Pre-disability Earnings means Your regular monthly rate of pay in effect for the 26 regular pay periods immediately prior to the date You became Disabled, divided by 12. Pre-disability Earnings includes overtime pay, bonuses, vacation pay, illness protection and personal pay, but not commissions or any other fringe benefits or extra compensation. If You have worked for less than 12 months with this Employer, Your regular monthly rate of pay will be based upon the total earnings You actually received while working for this Employer immediately prior to the date You became Disabled, annualized and divided by 12.

Prior Policy means the long term disability insurance carried by the Employer on the day before the Policy Effective Date.

Regular Care of a Physician means that You are being treated by a Physician:

1) whose medical training and clinical experience are suitable to treat Your disabling condition; and
2) whose treatment is:
   a) consistent with the diagnosis of the disabling condition;
   b) according to guidelines established by medical, research, and rehabilitative organizations; and
   c) administered as often as needed;

   to achieve the maximum medical improvement.

Related means Your spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

1) impairments in social and/or occupational functioning;
2) debilitating physical condition;
3) inability to abstain from or reduce consumption of the substance; or
4) the need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.

Total Disability or Totally Disabled means You are prevented from performing the Essential Duties of:

1) Your Occupation or a Reasonable Alternative Job offered to You by the Employer during the Elimination Period and for the 12 months following the Elimination Period, and as a result Your Current Monthly Earnings are less than 20% of Your Pre-disability Earnings; and.
2) after that, Any Occupation.

Your Disability must result from:

1) accidental bodily injury;
2) sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy.

Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation or a Reasonable Alternative Job offered to You by the Employer, alone, does not mean that You are Disabled.

Reasonable Alternative Job means a job with the Employer, within the same general location, the Essential Duties of which You are able to perform, and which considers Your prior education, training or experience, and with a rate of pay greater than 50% of Your Pre-disability Earnings.

The Policy means the policy which We issued to The Policyholder under the policy number shown on the face page.

We, Our, or Us means the insurance company named on the face page of The Policy.

You or Your means the person to whom this certificate is issued.

Your Occupation means the Occupation that You were routinely performing for the Employer immediately prior to the date You became Disabled. We will consider Your occupation as it is performed at Wal-Mart Stores, Inc.

ELIGIBILITY AND ENROLLMENT

Eligible Persons: *Who is Eligible for Coverage?*

All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage: *When will I become Eligible?*

You will become eligible for coverage on the later of:
1) the Policy Effective Date; or
2) the date on which You complete the Eligibility Waiting Period for Coverage.

See the Schedule of Insurance for the Eligibility Waiting Period for Coverage.

Enrollment: *How do I enroll for coverage?*

You may enroll at any time, however if You do not enroll during the Initial Enrollment Period, You will be considered a late enrollee. To enroll for coverage You must:
1) complete and sign a group insurance enrollment form which is satisfactory to Us; and
2) deliver it to the Employer.

Initial Enrollment Period:
Class 1: Between 120 and 180 days from Your date of hire.
Class 2: Within 90 days from Your date of hire.
Class 3: Within 90 days from Your date of hire.
Class 4: Within 60 days from Your date of hire.

PERIOD OF COVERAGE

Effective Date: *When does my coverage start?*

If You enroll during the Initial Enrollment Period, Your coverage will start on the date indicated below for Your class:
Class 1: The 181st day of continuous, full-time employment.
Class 2: The 91st day of continuous, full-time employment.
Class 3: The 91st day of continuous, full-time employment.
Class 4: The date You enter the eligible class.

If You are a late enrollee, coverage will start on the 1st day after meeting a 12 month waiting period from the date You enroll, provided You have been Actively at Work during the previous 6 month period.

Deferred Effective Date: *Will my coverage start or an increase in my coverage take effect if I am not Actively at Work on the date my coverage is to start or increase?*

If You are absent from work due to:
1) accidental bodily injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy;

on the date Your insurance or increase in coverage would otherwise have become effective, Your insurance, or increase in coverage will not become effective until You are Actively at Work one full day.

Changes in Coverage: *Do coverage amounts change if there is a change in my class or my rate of pay?*

Your coverage may increase or decrease on the date there is a change in Your class or Pre-disability Earnings. However, no increase in coverage will be effective unless on that date You:

1) are an Active Associate; and
2) are not absent from work during the 30 day period prior to the change in class or earnings due to being Disabled. If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Pre-disability Earnings will become effective until the date We receive notice of the change.

Change in The Policy: *What happens if the Employer changes the Policy?*

Any increase or decrease in coverage because of a change in The Policy will become effective on the date of the change, subject to the following provisions:

1) the Deferred Effective Date provision; and
2) Pre-existing Conditions Limitations.

Continuity From a Prior Policy: *Is there continuity of coverage from a Prior Policy?*

If You were:

1) insured under the Prior Policy; and
2) not eligible to receive benefits under the Prior Policy;

on the day before the Policy Effective Date, the Deferred Effective Date provision will not apply.

Is my coverage under The Policy subject to the Pre-existing Condition Limitation?

If You become insured under The Policy on the Policy Effective Date and were covered under the Prior Policy on the day before the Policy Effective Date, the Pre-existing Conditions Limitation will end on the earliest of :

1) the Policy Effective Date, if Your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Policy; or
2) the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.

The amount of the Monthly Benefit payable for a Pre-existing Condition in accordance with the above paragraph will be the lesser of:

1) the Monthly Benefit which was paid by the Prior Policy; or
2) the Monthly Benefit provided by The Policy.

No payment shall be made after the earlier to occur of:

1) the date payments would have ceased under the Prior Policy; or
2) the date payments cease under This Policy.

The Pre-existing Conditions Limitation will apply after the Policy Effective Date to the amount of a benefit increase which results from a change from the Prior Policy to The Policy, a change in benefit options, a change of class or a change in The Policy.

Do I have to satisfy an Elimination Period under The Policy if I was Disabled under the Prior Policy?

If You received monthly benefits for disability under the Prior Policy, and You returned to work as a Full-time Active Associate before The Policy Effective Date, then, if within 6 months of Your return to work:

1) You have a recurrence of the same disability while covered under The Policy; and
2) there are no benefits available for the recurrence under the Prior Policy;

the Elimination Period, which would otherwise apply, will be waived if the recurrence would have been covered without any further elimination period under the Prior Policy.

Termination: *When will my coverage stop?*

Your coverage will end on the earliest of the following:

1) the date The Policy terminates;
2) the date premium payment is due but not paid by the Employer;
3) the last day of the period for which You make any required premium contribution; or
4) the date Your Employer terminates Your employment. Your employment terminates on the date You cease to be a Full-time Active Associate in an eligible class for any reason, unless coverage is extended under the Continuation Provisions.

Continuation Provisions: *Can my insurance be continued?*

Your coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all Associates the same way. Continued coverage:

1) is subject to any reductions in the Policy;
2) is subject to payment of premium by the Employer; and
3) terminates when the Policy terminates or coverage for Your class terminates.

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

Leave of Absence or Layoff: If You are on a documented, approved leave of absence, other than Family or Medical Leave, or are temporarily laid off by the Employer due to lack of work, Your coverage may be continued for 90 days following the last day You are Actively at Work. If the leave terminates prior to the agreed upon date, or the lay-off becomes permanent, this continuation will cease immediately. No premium will be required during continuation for an approved leave of absence or layoff.

Family Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage may be continued for up to 12 weeks, or longer if required by other applicable law, following the date Your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately. No premium is due for You if Your coverage is continued in accordance with this provision.

Coverage while Disabled: *Does my insurance continue while I am Disabled and no longer an Active Associate?*

If You are Disabled and You cease to be an Active Associate, Your insurance will be continued:
during the Elimination Period while You remain Disabled by the same Disability; and
after the Elimination Period for as long as You are entitled to benefits under The Policy.

Waiver of Premium: *Am I required to pay Premiums while I am Disabled?*

No premium will be due for You after the Elimination Period, and for as long as benefits are payable.

Extension of Benefits for Disability: *Do my benefits continue if the Policy terminates?*

If You are entitled to benefits while Disabled and The Policy terminates, benefits:

1) will continue as long as You remain Disabled by the same Disability; but
2) will not be provided beyond the date We would have ceased to pay benefits had the insurance remained in force.

Termination of The Policy for any reason will have no effect on Our liability under this provision.

BENEFITS

Disability Benefit: *When do I qualify for Disability Benefits?*

We will pay You a Monthly Benefit if You:

1) become Totally Disabled while insured under The Policy;
2) are Totally Disabled throughout the Elimination Period;
3) remain Disabled beyond the Elimination Period; and
4) submit Proof of Loss to Us.

Benefits accrue as of the first day after the Elimination Period and are paid monthly. However, benefits will not exceed the Maximum Duration of Benefits.

Mental Illness And Substance Abuse Benefits: *Are benefits limited for Mental Illness or Substance Abuse?*

If You are Disabled because of:

1) Mental Illness that results from any cause;
2) any condition that may result from Mental Illness;
3) alcoholism; or
4) the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance;

then, subject to all other provisions of The Policy, We will limit the Maximum Duration of Benefits.

Benefits will be payable:

1) only for so long as You are confined in a hospital or other place licensed to provide medical care for the disabling condition; or:
2) if not confined, or after You are discharged and still Disabled, for a total of 24 months for all such Disabilities during Your lifetime.

Recurrent Disability: *What happens if I recover but become Disabled again?*

Periods of Recovery during the Elimination Period will not interrupt the Elimination Period, provided the accumulated total number of days You return to work as an Active Associate are no more than 180 with respect to Class 4 Associates, and no more than 30 with respect to Class 1, 2 and 3 Associates.

Any day within such period of Recovery, will not count toward the Elimination Period.

After the Elimination Period, if You return to work as an Active Associate and then become Disabled and such Disability is:

1) due to the same cause; or
2) due to a related cause; and
3) within 6 months of the return to work;

the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided The Policy remains in force.

If You return to work as an Active Associate for more than 6 months, any recurrence of a Disability will be treated as a new Disability. The new Disability is subject to a new Elimination Period and a New Maximum Duration of Benefits.

Period of Disability means a continuous length of time during which You are Disabled under The Policy.

Recover or Recovery means that You are no longer Disabled and have returned to work with the Employer and premiums are being paid for You.

Calculation of Monthly Benefit: *How are my Disability benefits calculated?*

If You remain Totally Disabled after the Elimination Period, We will calculate Your Monthly Benefit as follows:

1) multiply Your Pre-disability Earnings by the Benefit Percentage ;
2) compare the result with the Maximum Benefit ; and
3) from the lesser amount, deduct Other Income Benefits including any amount for which You could collect but did not apply, and all other income from any employer or for any work.

The result is Your Monthly Benefit.

Disabled and Working (Partial Disability) Benefits:
How are benefits paid when I am Disabled and Working?

If, while covered under this benefit, You are Disabled and Working, as defined, the following calculation is used to determine Your Monthly Benefit:

$$\text{Monthly Benefit} = \frac{(A - B)}{A} \times C$$

Where

A = Your Indexed Pre-disability Monthly Earnings.
B = Your Current Monthly Earnings.
C = The Monthly Benefit payable if You were Totally Disabled.

As used in this calculation, "Indexed Pre-disability Earnings" means Your Pre-disability Earnings adjusted annually by adding 7%. The first adjustment will be made on the first July 1st to occur following a period of 12 consecutive months, during which You have been continuously Disabled. After this first adjustment is made, Your Pre-disability Earnings will be increased by an additional adjustment of 7% on each subsequent July 1st, up to a maximum of 5 adjustments, provided You are receiving benefits at the time the adjustment is made.

Minimum Monthly Benefit:
Is there a Minimum Monthly Benefit?

Your Monthly Benefit will not be less than the Minimum Monthly Benefit shown in the Schedule of Insurance.

Partial Month Payment:
How is the benefit calculated for a period of less than a month?

If a Monthly Benefit is payable for a period of less than a month, we will pay 1/30 of the Monthly Benefit for each day You were Disabled.

Termination of Benefit Payment:
When will my benefit payments end?

Benefit payments will stop on the earliest of:

1) the date You are no longer Disabled;
2) the date You fail to furnish Proof of Loss;
3) the date You are no longer under the Regular Care of a Physician;
4) the date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;
5) the date of Your death;
6) the last day benefits are payable according to the Maximum Duration of Benefits Table shown below;
8) the date Your Current Monthly Earnings exceed 80% of Your Indexed Pre-disability Earnings; or
9) the date no further benefits are payable under any provision in The Policy that limits benefit duration.

Survivor Income Benefit:
Will my survivors receive a benefit if I die while receiving Disability Benefits?

If You were receiving a Monthly Benefit at the time of Your death, We will pay a Survivor Income Benefit, when We receive proof satisfactory to Us:

1) of Your death; and
2) that the person claiming the benefit is entitled to it.

We must receive the satisfactory proof for Survivor Income Benefits within 1 year of the date of Your death.

We will pay the Survivor Income Benefit:

1) to Your Surviving Spouse; or

2) if no Surviving Spouse, in equal shares to Your Surviving Children;
3) if no Surviving Spouse or Surviving Children, to Your estate.

However, We will first apply the Survivor Income Benefit to any overpayment which may exist on Your claim.

If a minor child is entitled to benefits, We may, at Our option, make benefit payments to the person caring for and supporting the child until a legal guardian is appointed.

The Survivor Income Benefit is a lump sum amount of $5,000.

Surviving Spouse means Your wife or husband who was not legally separated or divorced from You when You died.

Surviving Children means Your children, step children, foster children, and legally adopted children.

EXCLUSIONS AND LIMITATIONS

Exclusions: *What Disabilities are not covered?*

The Policy does not cover, and We will not pay a benefit for any Disability:
1) unless You are under the Regular Care of a Physician;
2) that is caused or contributed to by war or act of war (declared or not);
3) caused by Your commission of or attempt to commit a felony.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:
1) was sponsored by the Employer; and
2) was terminated before the Effective Date of The Policy;

no benefits will be payable for the Disability under The Policy.

Pre-Existing Condition Limitation: *Are benefits limited for Pre-existing Conditions?*

We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition, unless, at the time You become Disabled:
1) You have not received Medical Care for the condition for 365 consecutive day(s) while insured under The Policy; or
2) You have been continuously insured under The Policy for 730 consecutive day(s).

Pre-existing Condition means:
1) any accidental bodily injury, sickness, Mental Illness, pregnancy, or episode of Substance Abuse; or
2) any manifestations, symptoms, findings, or aggravations related to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, or Substance Abuse;

for which You received Medical Care during the 365 day period that ends the day before:
1) Your effective date of coverage; or
2) the effective date of a Change in Coverage.

Medical Care is received when a physician or other health care provider:
1) is consulted or gives medical advice; or
2) recommends, prescribes, or provides Treatment..

Treatment includes but is not limited to:
1) medical examinations, tests, attendance or observation; and
2) use of drugs, medicines, medical services, supplies or equipment.

GENERAL PROVISIONS

Notice of Claim: *When should I notify the Company of a claim?*

You must give Us written notice of a claim within 90 days after Disability occurs. If You cannot give notice within that time, You must give it to Us as soon as reasonably possible. Such notice must include Your name, Your address and the Policy Number.

Claim Forms: *Are special forms required to file a claim?*

We will send forms to You to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, You may submit any other written proof which fully describes the nature and extent of Your claim.

Proof of **Loss:** *What is Proof of Loss?*

Proof of Loss may include but is not limited to the following:

1) documentation of:
   a) the date Your Disability began;
   b) the cause of Your Disability;
   c) the prognosis of Your Disability;
   d) Your Pre-disability Earnings, Current Monthly Earnings or any income, including but not limited to copies of Your filed and signed federal and state tax returns; and
   e) evidence that You are under the Regular Care of a Physician;
2) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
3) the names and addresses of all:
   a) Physicians or other qualified medical professionals You have consulted;
   b) hospitals or other medical facilities in which You have been treated; and
   c) pharmacies which have filled Your prescriptions within the past three years;
4) Your signed authorization for Us to obtain and release:
   a) medical, employment and financial information; and
   b) any other information We may reasonably require;
5) Your signed statement identifying all Other Income Benefits; and
6) proof that You and Your dependents have applied for all Other Income Benefits which are available.

You will not be required to claim any retirement benefits which You may only get on a reduced basis. All proof submitted must be satisfactory to Us.

Additional Proof of **Loss:** *What additional proof of loss is the Company entitled to?*

To assist Us in determining if You are Disabled, or to determine if You meet any other term or condition of The Policy, We have the right to require You to:

1) meet and interview with our representative; and
2) be examined by a Physician, vocational expert, functional expert, or other medical or vocational professional of Our choice.

Any such interview, meeting or examination will be:

1) at Our expense; and
2) as reasonably required by us.

Your Additional Proof of Loss must be satisfactory to Us. Unless We determine You have a valid reason for refusal, We may deny, suspend or terminate Your benefits if You refuse to be examined or meet to be interviewed by Our representative.

Sending Proof of Loss: *When must proof of Loss be given?*

Written Proof of Loss must be sent to Us within 90 days after the start of the period for which We are liable for payment. If proof is not given by the time it is due, it will not affect the claim if:

1) it was not possible to give proof within the required time; and
2) proof is given as soon as possible; but
3) not later than 1 year after it is due, unless You are not legally competent.

We may request Proof of Loss throughout Your Disability. In such cases, We must receive the proof within 30 days of the request.

Claim Payment: *When are benefit payments issued?*

When We determine that You;

1) are Disabled; and
2) eligible to receive benefits;

We will pay accrued benefits at the end of each month that You are Disabled. We may, at Our option, make an advance benefit payment based on Our estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid as soon as Proof of Loss satisfactory to Us is received.

Claims to be Paid: *To whom will benefits for my claim be paid?*

All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:

1) Your estate;
2) a person who is a minor; or
3) a person who is not legally competent;

then We may pay up to $1,000 to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

Claim Denial: *What notification will I receive if my claim is denied*

If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:

1) give the specific reason(s) for the denial;
2) make specific reference to the Policy provisions on which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

Claim Appeal: *What recourse do I have if my claim is denied?*

On any claim, You or Your representative may appeal to Us for a full and fair review. To do so:

1) You must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
   b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
2) You may request copies of all documents, records, and other information relevant to Your claim; and
3) You may submit written comments, documents, records and other information relating to Your claim.

We will respond to You in writing with Our final decision on the claim.

Social Security: *When must I apply for Social Security Benefits?*

You must apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You must apply within 45 days from the date of Our request. If the Social Security Administration denies Your eligibility for benefits, You will be required:

1) to follow the process established by the Social Security Administration to reconsider the denial; and
2) if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

Benefit Estimates: *How does the Company estimate Disability benefits under the United States Social Security Act?*

We reserve the right to reduce Your Monthly Benefit by estimating the Social Security disability benefits You may be eligible to receive.

When We determine that You may be eligible for benefits, We may estimate the amount of these benefits. We may reduce Your Monthly Benefit by the estimated amount.

Your Monthly Benefit will not be reduced by estimated Social Security disability benefits if:

1) You apply for Social Security disability benefits and pursue all required appeals in accordance with the Social Security provision; and
2) You have signed a form authorizing the Social Security Administration to release information about awards directly to Us; and
3) You have signed and returned Our reimbursement agreement, which confirms that You agree to repay all overpayments.

If We have reduced Your Monthly Benefit by an estimated amount and:

1) You are later awarded Social Security disability benefits, We will adjust Your Monthly Benefit when We receive proof of the amount awarded, and determine if it was higher or lower than Our estimate; or
2) Your application for Social Security disability benefits has been denied, We will adjust Your Monthly Benefit when You provide Us proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals.

If Your Social Security benefits were lower than we estimated, and We owe You a refund, We will make such refund in a lump sum. If Your Social Security Benefits were higher than we estimated, and If Your Monthly Benefit has been overpaid, You must make a lump sum refund to Us equal to all overpayments, in accordance with the Overpayment Recovery provision.

Overpayment: *When does an overpayment occur?*

An overpayment occurs:

1) when We determine that the total amount We have paid in benefits is more than the amount that was due to You under the Policy; or
2) when payment is made by Us that should have been made under another group policy.

This includes, but is not limited to, overpayments resulting from:

1) retroactive awards received from sources listed in the Other Income Benefits definition;
2) failure to report, or late notification to Us of any Other Income Benefit(s) or earned income;
3) misstatement;
4) fraud; or
5) any error We may make.

Overpayment Recovery: *How does the Company exercise the right to recover overpayments?*

We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You will be required to sign when You become eligible for benefits under this Policy.

If benefits are overpaid on any claim, You must reimburse Us within [30 days.]

If reimbursement is not made in a timely manner, We have the right to:

1) recover such overpayments from:
   a) You;
   b) any other organization;
   c) any other insurance company;
   d) any other person to or for whom payment was made; and
   e) Your estate.
2) reduce or offset against any future benefits payable to You or Your survivors, [including the Minimum Monthly Benefit, until full reimbursement is made. Payments may continue when the overpayment has been recovered;
3) refer Your unpaid balance to a collection agency; and

pursue and enforce all legal and equitable rights in court.

Subrogation: *What are the Company's subrogation rights?*

If You:

1) suffer a Disability because of the act or omission of a Third Party;
2) become entitled to and are paid benefits under The Policy in compensation for lost wages; and
3) do not initiate legal action for the recovery of such benefits from the Third Party in a reasonable period of time;

then We will be subrogated to any rights You may have against the Third Party and may, at Our option, bring legal action against the Third Party to recover any payments made by Us in connection with the Disability.

Third Party as used in this provision, means any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under the Policy.

Legal Actions: *When can legal action be taken against Us?*

Legal action cannot be taken against Us:

1) sooner than 60 days after the date Proof of Loss is given; or
2) 3 years after the date written Proof of Loss is required to be given according to the terms of The Policy.

Fraud: *How does the Company deal with fraud?*

Insurance Fraud occurs when You and/or Your Employer provide Us with false information or files a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You and/or Your Employer commit Insurance Fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit Insurance Fraud. We will pursue all available legal remedies if You and/or Your Employer perpetrate Insurance Fraud.

Misstatements: *What happens if facts are misstated?*

If material facts about You were not stated accurately:

1) Your premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

No statement made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.

Policy Interpretation: *Who interprets the terms and conditions of The Policy?*

We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

ERISA INFORMATION

THE FOLLOWING NOTICE CONTAINS IMPORTANT INFORMATION

This employee welfare benefit plan (Plan) is subject to certain requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This document serves to meet ERISA requirements and provides important information about the Plan.

The benefits described in your booklet-certificate (Booklet) are provided under a group insurance policy (Policy) issued by the Hartford Life Insurance Company or the Hartford Life and Accident Insurance Company (Insurance Company) and are subject to the Policy's terms and conditions. The Policy is incorporated into, and forms a part of, the Plan. The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

A copy of the Plan is available for your review during normal working hours in the office of the Plan Administrator.

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1. **Plan Name**

   Group Long Term Disability Plan for employees of WAL-MART STORES, INC.

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2. **Plan Number**

   501

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3. **Employer/Plan Sponsor**

   WAL-MART STORES, INC.
   702 Southwest 8th Street
   Bentonville, AR 72716

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4. **Employer Tax Identification Number**

   71-0415188

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5. **Type of Plan**

   Welfare Benefit Plan providing Group Long Term Disability benefits.

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6. **Plan Administrator**

   WAL-MART STORES, INC.
   702 Southwest 8th Street
   Bentonville, AR 72716

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7. **Agent for Service of Legal Process**

For the Plan:

WAL-MART STORES, INC.
702 Southwest 8th Street
Bentonville, AR 72716

For the Policy:

Hartford Life and Accident Insurance Company
200 Hopmeadow St.
Simsbury, CT 06089

In addition to the above, Service of Legal Process may be made on a Plan trustee or the Plan Administrator.

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8. **Sources of Contributions** -- The Employer pays the premium for the insurance, but may allocate part of the cost to the employee. The Employer determines the portion of the cost to be paid by the employee.

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9. **Type of Administration** -- The Plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable Plan.

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10. The Plan and its fiscal records are kept on a Policy Year basis.

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11. **Labor Organizations**

None

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12. **Names, Titles and Addresses of the principal place of business for each Trustee of the Plan**

None

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13. **Plan Amendment Procedure**

The Employer reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

1. Receive Information About Your Plan and Benefits

a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.

c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

3. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

4. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210 . You may also obtain certain publications about your rights and

responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CLAIM PROCEDURES

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

Claim Procedures for Claims Requiring a Determination of Disability

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, 4) a description of the review procedures and time limits applicable to such procedures, 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal, and 6)(A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request, or (B) if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, we will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a statement that you have the right to bring a civil action under section 502(a) of ERISA, 4) a statement that you may request, free of charge, copies of all documents, records, and other information relevant to your claim; 5)(A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision on appeal, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the decision on appeal and that a copy will be provided free of charge to you upon request, or (B) if the decision on appeal is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the decision on appeal, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request, and 6) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.